South Carolina Department of Disabilities and Special Needs

Early Intensive Behavior Intervention Provider Enrollment Packet Checklist

Dear Provider:

We will inform the South Carolina Department of Health and Human Services (SCDHHS) that you are interested in becoming a Medicaid Provider to assist children in the Pervasive Developmental Disorder (PDD) Program. The following information is required by DHHS in order to process your application:

____ Signed cover letter stating you are requesting to become a Medicaid provider of PDD waiver services.

____ DHHS Form 219 Medicaid Enrollment Data Group CLTC Non-Contracted (provider type 62).

____ DHHS Form 219 Medicaid Enrollment Data Individual CLTC Non-Contracted (provider type 61).

____ SCDHHS Electronic Funds Transfer (EFT) Authorization Agreement (Revised 01/09).

____ Bank statement verifying EFT form.

____ CMS Form 1513 Disclosure of Ownership and Control Interest Statement.

____ W-9 Request for Taxpayer Identification Number and Certification.

____ Provider Enrollment Information for Participation in the Pervasive Developmental Disorder Waiver/State Funded Program (Form 22-B)

____ EIBI Provider Information Sheet (PDD Form 22-C)

All of the above information must be completed and returned to process your request. Incomplete application packets will be returned. Should you need further information about the first seven (7) documents, please contact Jon Tapley at DHHS @ 803-898-2702.

South Carolina Department of Disabilities and Special Needs

Provider Enrollment Information for Participation in the Pervasive Developmental Disorder Waiver/State Funded Program

Name: _____

Address: _____

_____

Telephone: _____ E-Mail: _____

Provider Type / Education (check one)

☐ Bachelor's Degree in _____ (Attach copy of diploma or transcript)

☐ Master's Degree in _____ (Attach copy of diploma or transcript)

☐ Doctorate Degree in _____ (Attach copy of diploma or transcript)

☐ Board Certified Assistant Behavior Analyst # _____ (Attach copy of current certification)

☐ Board Certified Behavior Analyst # _____ (Attach copy of current certification)

Provider Qualifications / Experience

☐ 1 year experience as an independent practitioner and/or has supervised a clinician with less experience.

☐ 2 years experience as an independent practitioner and/or has supervised a clinician with less experience.

☐ 3+ years experience as an independent practitioner and/or has supervised a clinician with less experience.

I certify the information given above concerning my credentials and work experience is accurate.

_____ _____

Enrollee's Signature Date

The information noted above and information submitted has been reviewed and verified.

_____ _____

DDSN – Autism Division Date

PDD WAIVER/STATE FUNDED PROGRAM
EIBI Provider Information Sheet

Welcome aboard! As a provider of Early Intensive Behavioral Intervention (EIBI) services through the PDD Waiver and PDD Stated Funded Program, your name or company name will be posted on the Department of Disabilities and Special Needs (DDSN) web site. This posting will enable recipients of PDD services to determine if you are an EIBI provider in their county. As such, a parent may call you to get additional information (e.g. your philosophy pertaining to ABA, a projected date at which you can begin, etc.) as they search for an EIBI provider for their child. Once you complete this sheet, please e-mail or fax me this document per the information at the bottom of this page.

Required Information

Provider Name:

Address:

Phone Number:

Executive Director's Name:

Counties to be Served:

Optional Information

Fax Number:

E-mail address:

Up to 2 additional contact names, addresses, and phone numbers

Daniel Davis
Director, Autism Division

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